PLANNING COMMITTEE MEETING
SUMMARY NOTES

FRIDAY, NOVEMBER 21, 2003 · 10:30 – 12:00 P.M. · PT. LOMA NAZARENE UNIVERSITY

I. Welcome and Introductions

Welcome by Evalyn Greb, followed by self-introductions of forty-six stakeholders in attendance.

II. Announcements

- LTCIP Health Plan Partners Meeting following this meeting at Aging & Independence Services (AIS), 12:30-2:00 in Training Room
- Mental Health & Substance Abuse Workgroup:
    - Smaller Working Committee met on October 21st & November 13th and 19th to discuss options for including mental health and substance abuse in LTCIP. Next meeting is December 18, 2003 from 2:30-4:00 at AIS in the Training Room.
    - Next Full Workgroup meeting: January 7, 2004 from 4 to 5:30 PM at PLNU
- No December Planning Committee meeting

III. Why We've Asked MassHealth Senior Care Options To Be Here

Mark Meiners, National Program Director, RWJF Medicare/Medicaid Integration Program, introduced his MMIP guest speaker, Diane Flanders, and gave a brief overview of how the SCO model matches closely with both the local LTCIP stakeholder vision and the recent proposal by the LTCIP consultant team for developing the HSD+ model.

IV. Presentation on the MassHealth Senior Care Options

Diane Flanders, Director, Coordinated Care Systems, MA Division of Medical Assistance, presented on the newly authorized MassHealth Senior Care Options Program. The full PowerPoint presentation and revised matrix are available on the LTCIP website or can be requested by calling 858-495-5428; audio recording available at http://www.hhp.umd.edu/AGING/MMIP/sandiegoflanders.HTML. The following bullets highlight key elements of the Mass SCO model:

- Voluntary program that targets seniors age 65+ (eligible to Medicaid-only and eligible to Medicare and Medicaid or "duals"). There is significant interest in phasing-in younger disabled population in the future. Program is voluntary given that Medicare enrollment cannot be mandated.

- Qualified Senior Care Organizations (SCOs – a.k.a. provider networks) will provide a fully integrated geriatric model of care and will be accountable for complying with nationally accepted quality of care standards. SCOs will authorize, deliver, and coordinate all services currently covered by Medicare and Medicaid, including (1) Primary, acute and specialty care (2) Community and institutional long term care (3) Behavioral health (4) Medical transportation and (4) Pharmaceuticals.

- Three qualified provider networks have submitted proposals to become SCOs. SCOs are provider networks, not insurance companies; SCOs are not required to be licensed HMOs.

- The program is expected to begin enrolling clients December 2003, with service provision projected for January 2004. Although there is no enrollment cap, projected enrollment for the first year is 300 clients per month.

- SCOs are required to contract with local Area Agencies on Aging (AAAs) for Geriatric Support Services Coordinators (GSSCs) who will manage community long-term care services as a member of the primary care management team. Rationale - utilizing a recognized and respected community-based aging network establishes trust among clients and caregivers, demonstrates a local & state-based alliance and reduces the fragmentation in providing health and social services across all settings.

- State does not require SCOs to contract with all traditional providers, but SCOs must demonstrate that they are able to provide the full range of Medicare and Medicaid services; enrollee preference will ultimately determine the community-based organizations with which SCOs contract.

- Medicare risk adjusters for three populations: institutionalized, community frail (who meet the state's nursing facility criteria), and community other (or community well population).

- MassHealth (the Medicaid capitation) has rating categories for four populations: institutionalized, community frail, community with diagnosis of Alzheimer's/dementia or chronic mental illness, and community other. Medicaid must cost no more than it would have under fee-for-service.

- Medicaid rates were developed through linked Medicare and Medicaid administrative claims data, which were trended forward by actuaries in accordance with CMS requirements for Medicaid managed care. As part of this process, direct 1915 (c) waiver services and costs could not be referenced in SCO rate development, so the State was allowed to substitute State Plan services and costs for equivalent HCBS (i.e., 1915 (c) waiver includes "social day care," so "adult day health" was substituted into rate structure). In general, this substitution exercise allowed for sufficient flexibility in SCO Medicaid rate to provide needed HCBS.

- Staff at the Centers for Medicare and Medicaid (CMS) envision the SCO model to be a viable "off-the-shelf" model for other states to follow.

VII. Group Discussion

- Please refer to audio recording for more detail.

VIII. Adjourn

NO DECEMBER PLANNING COMMITTEE MEETING – HAPPY HOLIDAYS

STAY TUNED FOR JANUARY ANNOUNCEMENT